DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/14/2016 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938/0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA (DENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY A. BUILDING COMPLETED 445511 NAME OF PROVIDER OR SUPPLIER 09/28/2016 STREET ADDRESS, CITY, STATE, ZIP CODE LIFE CARE CENTER OF COLTEWAH 5911 SNOW HILL ROAD OOLTEWAH, TN 37363 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION PREFIX TAG TAG DATE **DEFICIENCY**) F 000 INITIAL COMMENTS F 000 AMENDED 10/14/16 to remove resident #31 from F514 and and F520 to the Initial Comments AMENDED on 10/13/16: F514 Increased scope and severity F514 Resident #31 removed from the tag During the annual Recertification survey and Investigation of complaints #38335, #39482, and #39713 conducted on 9/26-28/16 at Life Care Center of Ooltewah, no deficiences were cited in relation to complaints #38335 and #39713. Deficiencles were cited at F280, F314, F514, and F520 with a s/s of G under 42 CFR PART 483 Requirements for Long Term Care Facilities. 483.20(d)(3), 483.10(k)(2) RIGHT TO F 280 1) What Corrective action(s) will be PARTICIPATE PLANNING CARE-REVISE CP SS=G accomplished for those residents founds to have been affected by the The resident has the right, unless adjudged incompetent or otherwise found to be deficient practice. incapacitated under the laws of the State, to On 10/13/16 the care plan for Resident participate in planning care and treatment or #26 was revised by an RN to utilize changes in care and treatment. a right knee brace sleeve A comprehensive care plan must be developed (immobilizer) when participating in within 7 days after the completion of the therapy only, and for therapy to assess comprehensive assessment; prepared by an skin integrity after each treatment interdisciplinary team, that includes the attending session. The therapist will document findings physician, a registered nurse with responsibilit in the dally notes, and if any changes are for the resident, and other appropriate staff in disciplines as determined by the resident's needs, noticed they will report to the Director of and, to the extent practicable, the participation of Rehab/Assistant Director of Rehab, and the resident, the resident's family or the resident's 10/28/16 Nurse. tegal representative; and periodically reviewed 2) How you will identify other residents and revised by a team of qualified persons after having the potential to be affected by each assessment. the same deficient practice and what corrective action will be taken. LABORATORY DIRECTOR'S OR PROVIDER/BUPPLIER REPRESENTATIVES SIGNATURE txecutive Director Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14

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days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

Facility (D: TN3317

If continuation sheet Page 1 of 17

CENTE	KS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			· FOR	ED: 10/14/201	D
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IFLE CONSTRUCTION (X3) I	O: 0938:039 ATE SURVEY OMPLETED	11
NAME OF	PROVIDER OR SUPPLIER	446511	L	B, WING_		9/28/2016	
	RE CENTER OF OOL	EWAH	٠.		STREET ADDRESS, CITY, STATE, ZIP CODE 5911 SNOW HILL ROAD OOLTEWAH, TN 37363	212012010	
(X4) ID PREFIX TAG	₹ (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORPECTION	COMPLETION DATE	
F 280	Continued From particles	ge 1 IT is not met as evidenced		F 28	F280 Continued Alt residents have the potential to be affected by failing to care plan interventions to include orthotic devices and skin integrity.		
	and interview, the fa plan for 1 (#26) resid	ecord review, observation, cility failed to revise a care dent with an immobilizer, o ed, resulting in Harm to the			An audit was conducted to identify all residents with orthotic devices to ensure care plan interventions include assessment of orthotic device and skin		
	admitted to the facili including Fracture of	d: w revealed Resident #26 v ty on 8/18/16 with diagnosi Lower End of Right Femu Heart Fallure, and Anemia	8		integrity by Director of Nursing, Director of Rehab, Registered Nurse and/or designee by 10/13/16. All care plans were reviewed and revised as a result of the audit by the DON and RN by 10/13/16.	10/28/16	
	oviavio revesico.""	w of the care plan dated Knee Immobilizer R [Right] iew revealed no Intervention Iment of the knee	ns		3) What measure will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur.		***************************************
	dated 8/27/16 reveal bathed and 2 new wo distal end of the calf. approximately the sig Wounds were covere [Physician] was notififor any changesAd [physician] intervention	te of a 50 cent piece. ed by the knee immobilizer edwill continue to monito dendum Clarification; MD on was to loosen brace"			All licensed nurses will be In-serviced on the care plan revision process (Exhibit A) to include assessment of orthotic device and skin Integrity by the Director of Nursing, Assistant Director of Nursing, and Staff Development Coordinator or designee by 10/26/16, Any Licensed Nurses that have not been		
·	Status Record dated first observed 8/29/10 Extremity] (posterior-	of the Pressure Ulcer 8/29/16 revealed "Date 5 Location RLE [Right Low lateral aspect) stage 1 x [by] 3.5 [width] cm	er		in-serviced will not be allowed to work until in-service completed.	10/28/16	

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/14/2016 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A BUILDING COMPLETED 445511 B, WING 09/28/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5911 SNOW HILL ROAD LIFE CARE CENTER OF COLTEWAN OOLTEWAH, TN 37363 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F280 Continued ·F 280 Continued From page 2 F 280 All MDS Coordinators will be in-serviced [centimeters] depth 0...Necrotic Tissue on the care plan revision process to 100%...drainage small...color serous include assessment of orthotic device sanguinous..." and skin integrity by Director of Nursing Medical record review of a Physician's Order or RN designee by 10/26/16. dated 8/30/16 revealed "... New Tx [treatment]. .. R All licensed nurses and therapist will be lower leg-posterior of [clean][with] [wound educated on the Orthotic Device cleanser] apply lodosorb cover [with] dry dsg Documentation and Communication [dressing] [change] QOD [every other day] [and] pm [as needed]..." Process (Exhibit B) by the DOR, ADOR, DON, ADON, or SDC/ designee by 10/26/16 Observation with Registered Nurse (RN) #1 or 9/26/16 at 11:00 AM revealed the resident sealed This training will also be completed in in a wheelchair in the resident's room with an orientation for all new licensed nurse immobilizer on the right lower extremity. associates. Interview with the resident's physician on 9/28/66 The Director of Nursing, Assistant, at 12:05 PM, in the conference room, confirmed

F 314

\$\$=G

Refer to F-314 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES

in development of pressure ulcers.

Based on the comprehensive assessment of a resident, the facility must ensure that a resident Who enters the facility without pressure sores does not develop pressure sores unless the

the physician expected staff to regularly assess

Interview with the Director of Nursing (DON) of

confirmed the care plan had not been updated for

9/28/16 at 2:10 PM, in the conference room,

the assessment of the knee immobilizer. The

failure to care plan interventions to include assessment of the immobilizer and skin resulted

the resident's immobilizer and skin for skin

F 314

4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur.

Director of Nursing, and Unit Manager

physician's orders and ensure that care

orthotic device and skin integrity in the

plan interventions include assessment of

Clinical Am Meeting, which consists of DON

ADON, DOR or ADOR, MDS Coordinator,

and Unit Managers, 5 times per week for

one month, 3 times a week for one month,

and then 1 time a week for one month.

will use an audit tool to audit all new

10/28/16

impairment.

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/14/2016 CENTERS FOR MEDIGARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES 1880 8880 ON BMO (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 445511 NAME OF PROVIDER OR SUPPLIER 09/28/2016 STREET ADDRESS, CITY, STATE, ZIP CODE LIFE CARE CENTER OF OOLTEWAH 5911 SNOW HILL ROAD OOLTEWAH, TN 37363 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F280 Continued F 280 Continued From page 2 F 280 Director of Nursing or Assistant [centimeters] depth 0...Necrotic Tissue 100%...drainage small...color serous Director of Nursing will present bi-monthly \$anguinous..." the results of the audits and education as indicated to the facility Performance Medical record review of a Physician's Order Improvement (PI) Committee. This dated 8/30/16 revealed "...New Tx [treatment] ...R lower leg-posterior of [clean][with] [wound committee consisting of the Executive cleanser] apply todosorb cover [with] dry dsg Director, Director of Nursing, Medical [dressing] [change] QOD [every other day] [and] Director, Director of Maintenance, pm [as needed]..." Director of Rehab, Health Information Observation with Registered Nurse (RN) #1 oh Management Director. 9/26/16 at 11:00 AM revealed the resident seated Director of Food and Nutrition Services, in a wheelchair in the resident's room with an Director of Environmental Services. immobilizer on the right lower extremity. Director of Social Services, Business Office Manager, Director of Admission, Interview with the resident's physician on 9/28/16 and Director of Activities will review the at 12:05 PM, in the conference room, confirmed the physician expected staff to regularly assess findings and make recommendations the resident's immobilizer and skin for skin and develop plans of action if any areas impairment. are noted to be non-compliant. 10/28/16 Interview with the Director of Nursing (DON) on 9/28/16 at 2:10 PM, in the conference room, confirmed the care plan had not been updated for

F 314

Refer to F-314 483.25(c) TREATMENT/SVCS TO SS=G | PREVENT/HEAL PRESSURE SORES

in development of pressure licers.

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the

the assessment of the knee immobilizer. The fallure to care plan interventions to include assessment of the immobilizer and skin resulted

1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.

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DEPARTMENT OF HEALTH AND HUMAN SERVICE CENTERS FOR MEDICARE & MEDICARD SERVICES (XX) PROVIDER/SUPPLIER/						- FC	ORMA	10/14/2016 PPROVED
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		445511		B. WING			55/5	0.0044
NAME OF I	ROVIDER OR SUPPLIER		_			TREET ADDRESS, CITY, STATE, ZIP CODE	09/2	8/2016
LIFE CA	RE CENTER OF OOLT		!		5	911 SNOW HILL ROAD POLTEWAR, TN 37363		
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F 314	they were unavoidal pressure sores rece	condition demonstrates that ole; and a resident having lives necessary treatment healing, prevent infection	and :	F3		F 314 Continued On 10/13/16, Resident #26 had physician order clarification by an RN to utilize right knee brace sleeve (immobilizer) when participating in therapy only, and for therapy to assess skin integrity after each		
	by: Based on facility poreview, observation, failed to prevent deviated to provide treated assessment of pres (#26) of 3 residents	IT is not met as evidenced and interview, the facility velopment of pressure ulcers at complete an accurate sure ulcers for 1 resident reviewed, resulting in Harm to	13, 15		The second secon	treatment. The therapist will document fir in the daily notes, and if any changes are noticed they will report to the Director of Rehab/Assistant Director of Rehab, and Nurse. On 9/27/16 Director of Nursing provided education to RN #2 on following the Medication Administration Policy and Procedure	e [G ·
11 17	dated 2/25/15 revea treatment order that followingSite.of wo cleanserName of c	policy Treatment Orders led "the physician writes includes at least the bundName of pintmentType of	a			(documentation process). On 10/26/16 SDC/designee will provide education to RN #2 on Wound Care procedure and Wound Care/Treatment Evaluation.		
	Review of the facility Wounds dated 2/25/ responsibility of a lic wound assessment findingsInclude a cincluding its physical medical record,"	of times to perform the sician order is followed" y policy Assessment of 16 revealed "It is the ensed nurse to complete and to document the description of the wound, is characteristics, in the work were aled Resident #26	-			The Nurse who documented the progress note on 8/27/16 will receive education by the DON, ADON, or SDC/Designee on completing a Pressure Ulcer Assessment and documenting assessment at the time of identification and Pressure Ulcer/Non-Pressure Treatment Plan (algorithm) by 10/26/16.	1	0/28/16
	admitted to the facili	ty on 8/18/16 with diagnos	vas es					

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/14/2016 CENTERS FOR MEDICARE & MEDICATO SERVICE FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLU IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY A. BUILDING COMPLETED 445511 B. WING NAME OF PROVIDER OR SUPPLIER 09/28/2016 STREET ADDRESS, CITY, STATE, ZIP CODE LIFE CARE CENTER OF OOLTEWAH 5911 SNOW HILL ROAD OOLTEWAH, TN 37363 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F314 Continued F 314 Continued From page 4 F 314 The Director of Nursing, Assistant including Fracture of Lower End of Right Fentur, Chronic Congestive Heart Failure, and Anemia. Director of Nursing, Staff Development Coordinator, Unit Managers, MDS Medical record review of the Weekly Skin Coordinators, and 2nd shift supervisor. Integrity Data Collection record dated 8/22/16 will be educated on the ABCs of revealed no documentation of skin breakdown on Wound Care (Exhibit C) (online credentialed the right lower posterior leg. continuing education) by 10/26/16. 10/28/16 Medical record review of a physical therapy note dated 8/22/16 revealed, "... Therapist repositioning 2) How you will identify other residents R [right] knee immobilized due to downward having the potential to be affected by slipping of immobilizer, and poor positioning. Kne the same deficient practice and what [knee] examined bby [by] both MD [physician] and therapist this date. Edema [swelling] continues to correct action will be taken. be present this date. After repositioning and All residents with orthotic devices have Securing of immobilizer..." the potential to be affected by failing Medical record review of a Nurses Progress Note to prevent development of pressure electronically signed by the nurse on 8/27/16 at ulcers, provide treatment of pressure 6:21 PM, revealed "...pt [patient] was being ulcers as ordered, and a complete bathed and 2 new wounds were found on the and accurate assessment of pressure distal end of the calf. Wounds were approximately the size of a 50 cent piece. ulcers. Wounds were covered by the knee immobilizer. [Physician] was notified and no new orders were Unit Managers, Assistant Director of given at this time, will continue to monitor for any Nursing, and MDS Nurses changes..." Further review revealed an addendum note electronically signed by the nurse conducted a 100% skin audit that on 8/29/16 at 1:36 AM., "...Addendum included residents with orthotic devices Clarification: MD intervention was to loosen to ensure assessment of skin integrity brace, not no new orders." to prevent development of pressure

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Medical record review of a Rehabilitation Services

Multidisciplinary Screening tool completed by the

[posterior lateral right lower extremity] measuring

physical therapist on 8/29/16 revealed, "Pt

[patient] presents [with] wound to post/lat R L

8 x [by] 3.5 x 0 cm [centimeters] [with] 100%

eschar to distal end of wound and SDTI

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were identified.

ulcer and if applicable provide treatment

accurate assessment of pressure ulcer

by 10/13/16. No new pressure ulcers

of pressure ulcer and complete an

If continuation sheet Page 5 of 17

10/28/16

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/14/2016 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CHA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 445511 B. WING 09/28/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5911 SNOW HILL ROAD LIFE CARE CENTER OF COLTEWAH OOLTEWAH, TN 37363 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE. PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY F314 Continued Continued From page 5 F 314 The Pressure Ulcer Treatment Records of [suspected deep tissue injury] to proximal end of wound. Wound is irregularly shaped [with] residents with pressure ulcers were distinct borders. Minimal serousanguinal reviewed, and visual inspection of drainage noted from distal end of wound dressings was conducted by the DON. (minimal). Dr [name], Dr [name], Nsg [nursind] ADON, and/or designee to ensure manager present for screen/assessment. Appears brace (R knee immobilizer) may have treatments are completed as ordered contributed to pressure...Advised foam dag by 10/19/16. [dressing] can be used to provide padding from The Pressure Ulcer Status Records brace. Ed [educate] nsg staff & [and] pt/sitter on appropriate fitting of brace to maintain neutral were reviewed by the DON, ADON, alignment and reduce pressure..." and/or designee to ensure a thorough assessment of the pressure ulcers, Medical record review of the Pressure Ulcer including stage, size, and character Status Record dated 8/29/16 revealed "...Date was conducted and documented by --first observed 8/29/16 [same wound as described in nurse progress notes dated 8/27/16] Location 10/19/16. 10/28/16 RLE [Right Lower Extremity] (posterior-lateral 3) What measure will be put into aspect) stage unstageable 8 [length] x 3.5 [width] place or what systematic changes cm [centimeters] depth 0...Necrotic Tissue you will make to ensure that the 100%...drainage small...color serous sanguinous..." deficient practice does not recur. Medical record review of a physician's note dated All licensed nurses and therapists will 8/29/16 at 3:04 PM revealed, "...[Resident #26 be educated on the Orthotic Device has developed a new wound on the lateral R Documentation and Communication lower leg under the immobilizer... The rigid bar Process by the Director of Rehab. along the side of the immobilizer may be contributing to these wounds. Continue local Assistant Director of Rehab, Director wound care. Attempt to adjust immobilizer ... * of Nursing, Assistant Director of Nursing, or Staff Development Medical record review of a Physician's Order Coordinator/designee by 10/26/16. dated 8/30/16 revealed "...New Tx [treatment] R

pm [as needed]...:

lower leg-posterior of [clean] [with] [wound

cleanser] apply lodosorb cover [with] dry dsg

Medical record review of a Physician's Order

[dressing] [change] QOD [every other day] [and]

This training will be completed in

and therapy associates.

orientation for all new licensed nurse

10/28/16

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICE	S .		Р	RINTEI	D;: 10/14/20 ⁻	16
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1 STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER	a	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) D4	D. 0938-039 ATE SURVEY MPLETED	11
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F 314	Continued From page	de 5		W	F314 Continued		 	٦
		sue injury) to proximal er	40€	F 314	The Director of Nursing, Assistant			
	wound. Wound is in	regularly shaped (with)	u b:		Director of Nursing, Staff			ĺ
	distinct borders. Mil	nimai serousanguinai 📑			Development Coordinator, Unit		1 .	İ
	drainage noted from	distal end of wound	- 1		Managers, MDS Coordinators, and			
iſ	(minimal). Dr [name], Dr [name], Nsg [n manager present for screen/assessmen Appears brace (R knee immobilizer) ma	e], Dr [name], Nsg [nursi	ıg)					ı
4		r screen/assessment			Second Shift Supervisor will be		i	1
	contributed to press	ureAdvised foam dan 1	Ī		educated on the ABC's of Wound	_		ļ
	(dressing) can be us	ed to provide nadding fo	om 1		Care (credentialed continuing educat	ion)		ľ
	orace. Ed [educate]	nsg staff & fand) nt/sitte	ton l		by 10/26/16. This is an online course			Ė
į	alignment and reduce	brace to maintain neutra	ıt		with certificate of completion that		k	
ļ	B. Interit and Least	e pressure	1		includes prevention of pressure ulcer	3,	ľ	1
i	Medical record revie	w of the Pressure Lilcer	:		providing treatment of pressure ulcer		l	ľ
1	Status Record dated	[8/29/16 revealed " Del	e .		and accurately assessing pressure.	eeting .		ľ
	Tirst observed 8/29/1	6 isame wound as deed	أد محطة		ulcers.	• • •		١
ļ	m curse progress no)(es dated 8/27/16) / 2024	ion 1		All licensed nurses will be educated			ŀ
	aspect) stage unstage	ktremity] (posterior-latera peable 8 [length] x 3.5 [w] :akt.1		on the Medication Administration			İ
	em (centimeters) det	oth ONecrotic Tissue 1	onii		Policy and Procedure and Wound		ľ	l
1	100%drainage sma	Allcolor serous			Care Procedure and Wound Care/			ŀ
- 1	"…ຂນຸດການຊູກຣອ				Treatment Evaluation to ensure			ŀ
	Medical manni review			1	treatment orders are completed per			ı
1	8/29/16 at 3:04 PM r	w of a physician's note o evealed, "[Resident #2	ated		physicians order by the DON, ADON,			ı
	nas developed a nev	V Wound on the lateral Ri	- 4		SDC/Designee by 10/26/16,		l	Į,
#	lower leg under the li	mmobilizerThe rigid ha	-	ĺ	All licensed nurses will be educated			ľ
4 .	along the side of the	immobilizer may be		j	by the DON, ADON, SDC or Designer		4	ŀ
4 ,	contributing to these	wounds. Continue loca		ľ	on completing a Pressure Ulcer	5		
	would cale. Altemp	t to adjust immobilizer			Assessment and documenting		r	
1	Medical record review	w of a Physician's Order	1		assessment at the time of identification	. 1		ľ
- 10	dated 8/30/16 reveal	ed "New Tx Streatment	R		and Pressure Ulcer/Non-Pressure	11		l
- {1	lower leg-posterior di	[clean] (with) [wound [1.	Ulcer Treatment Plan (algorithm)			
} ,	deanserj apply lodos	orb cover [with] dry dsg			by 10/26/16.	1		
. [om (as needed)"	OD [every other day] [a	id]				: İ	
'	em feo mededin		1		Any licensed associates that have not	:	ļ	<u>}</u>
	Medical record review	y of a Physician's Order	F		been in-serviced will not be allowed to	world	10/28/16	ŀ
	7(02.00) Postdoug Mercions (N				until in-service completed.		10/20/10	Ė

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR:MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION

PRINTED: 10/14/2016 FORM APPROVED

STATEMEN	TOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLI/		(VO) Au	TIE		OMB NO	0938-03	93
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MANUE OF	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·			3	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> 09</u>	/28/2016	٠,
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	· · · · · · · · · · · · · · · · · · ·					OLTEWAH, TN 37363			
(X4) (D	SUMMARY STA	TEMENT OF DEFICIENCIES		, ID					ان
PREFIX TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SC (DENT(FYING INFORMATION)		PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	N ==	COMPLETION DATE	N
F 314	Continued From pa	ge 5]	314	F314 Continued			ᅦ
	[suspected deep tis	Sue injury) to province ea	1 of	} "	714	The Dissert of Street		<u> </u>	ļ
	i wound, vyound is ii	requiarly shaped fwith:	u Oi			The Director of Nursing, Assistant			-
	alsanci borgers. Mi	nimal serousanounal		1		Director of Nursing, Staff Developm	ent		-1
	drainage noted from	distal end of wound		1		Coordinator, Unit Managers, MDS		Ĺ	-
	(minimal). Dr [name	e], Dr [name], Nsg [nursin	g)			Coordinators and Second Shift		<u> </u>	
	manager present to	FSCFè6n/assessment i		ł	İ	Supervisor will audit Medication		Ĭ	-
	Contributed to proce	nee immobilizer) may hav ureAdvised foam dsg	e		- 1	Administration Records for all reside	nts with		
	idressing) can be us	ed to provide padding fro		1	Í	orthotic devices to ensure assessme	enf	ŀ	Į
	Drace. ⊨d (éducate)	INSO Staff & fandi nt/eitted	on.			of skin integrity to prevent developm	ent i		
	appropriate titling of	brace to maintain neutral	` ''		- }	of pressure tilcer in the Clinical AM	OIIL		3
,	alignment and reduc	æ pressure"]		ľ	Meeting, which consists of the DON	ADOM	Ì	1
	Madical		1		Į	DOR or ADOR, MDS Coordinator, a	MDOIN,		-
	Status Record dates	w of the Pressure Ulcer				Managers, 5 times a week for one m	io Unit		1
1	first observed 8/20/4	8/29/16 revealed "Date 6 [same wound as descr	: :=			3 times a week for one month, and	onth,		İ
ł	in nurse progress no	tes dated 8/27/16] Locati	bed	د د مهر	_,	1 time a week for one month, and			ſ
J.	WITE IKIBUL FOWEL FO	ktremity) (posterior-lateral	1		4	1 time a week for one month.			1
ľ	aspect) stage unstag	deable 8 (length) y 3 s hol	dth)		- 3				1
	ent feeutiwetets) dei	oth 0Necrotic Tissue I	<u>_</u>		1	The DON, ADON, SDC, Unit Manag	ers,		ı
	100%drainage sm	allcolor serous	- {		ı	MDS Coordinators and 2nd Shift			ı
ļ	sanguinous"	1	ı		1	Supervisor will randomly audit two	q		١
ļ	Medical record revie	w of a physician's note da			ľ	Pressure Ulcer Treatment Records	of 1		1
[8/29/16 at 3:04 PM r	w of a physician's note da evealed, "[Resident #26	ted			residents with pressure ulcers to			Ī
	has developed a nev	wound on the lateral R	ן עי	•	-4	visually inspect dressing to ensure	j		Į,
1	lower leg under the l	mmobilizer. The rigid bok				pressure ulcer treatments are condu	ctod 1		ŀ
1	along the side of the	immobilizer may be			ŀ	as ordered 5 times a week for two w	oolea		Ŀ
1	contributing to these	Wounds. Continue tocal			- 1	3 times a week for two weeks, 1 time	ECKS,		F
	wound care. Attemp	t to adjust immobilizer"	- 1		- {	a week for one month, and one time	†		F
	Medical record social	wof - Dhamin				for one month.	1		1
}	dated 8/30/16 review	w of a Physiclan's Order ed "New Tx [treatment	<u>,</u> 1			one monar.	1]:
	lower leg-posterior d	ctNew 1x [treatment] [clean] [with] [wound	ĸį				}		1.
ľ	deanser] apply lodo:	Sorb cover [with] dry dea	1				}		ľ
	[dressing] (change] (20D [every other day] [an	di I						ŀ
	pm (as needed)"		-						
{	Medical record review	w of a Physician's Order						10/28/16	ľ

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION AND PLAN OF CORRECTION AND PLAN OF CORRECTION A SULDING BEFORM A SULDING A SULDING A SULDING A SULDING A SULDING BEFORM A SULDING A SULDING A SULDING A SULDING A SULDING A SULDING A SULDING A SULDING A SULDING A SULDING A SULDING A SULDING A SULDING A SULDING A SULDING A SULDING A SULDING A SULDING A SULDING BEFORM A SULDING A SULDING BEFORM A SULDING BEFORM A SULDING BEFORM A SULDING BEFORM A SULDING BEFORM BEFORM BEFORM BEFORM BEFORM BEFORM BEFORM BEFORM BEFORM BEFORM BEFORM BEFORM BEFORM BEFORM BEFORM B	CENTER	RS FOR MEDICARE	AND HUMAN SERVICES				<u>,</u> f	FORM	10/14/2010 APPROVED)
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Medical record review of the treatment administration record for September 2016 revealed "RLE Posterior: Cleanse [with] NSS, pat dry. Apply iodosorb, cover [with] dry dsg [change] QOD [and] prn" Continued review revealed the treatment record was initialed on 9/24/18, indicating wound care had been completed. Observation with Registered Nurse (RN) #1 on 9/26/16 at 11:00 AM, revealed the resident seated in a wheelchair in the recident's room. Continued observation revealed a dressing to the right lower extremity dated 9/22/16 (4 days prior). Interview with RN #1 on 9/26/16 at 11:10 AM, at the nursing station, confirmed the dressing was ordered to be changed every other day. Observation of Resident #26's wounds and interview with Llcensed Practical Nurse #1 (LPN) on 9/26/16 at 12:15 PM, revealed LPN #1 described the wound on the posterior RLE as 2 areas, both 100% necrotic, with a small amount of brown drainage due to the product applied o the wounds. The wounds measured 3 cm (centimeters) length x 1.2 cm width x 0 cm depth. Medical record review of a nursing note dated 9/26/16 at 7:50 PM revealed, "LE [late entry] for 9/24/16: RLEcleanse and dressing change not		[and] prn"	· ·	,				•		1
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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/14/2016 CENTERS FOR MEDICARE & MEDICAIO SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A BUILDING ... 445511 B, WING NAME OF PROVIDER OR SUPPLIER 09/28/2016 STREET ADDRESS; CITY, STATE, ZIP CODE 6911 SNOW HILL ROAD LIFE CARE CENTER OF COLTEWAH OOLTEWAH, TN 37363 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (XS) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) F 314 Continued From page 7 F 314 willing to come into her room to have dressings changed. Second attempt, this nurse talked of into a dressing change, but was called away to another patient" Interview with the Director of Nursing (DON) dn 9/27/16 at 7:45 AM, in the DON's office. confirmed the treatment record was not to be signed prior to providing wound care and the dressing change had not been completed as documented on 9/24/16 Interview with Registered Nurse (RN) #2 (nurse who documented treatment completed on 9/24/16) on 9/27/16 at 2:05 PM, at the Nursing Station, confirmed RN #2 had signed the treatment record as having provided wound care, and had failed to provide treatment to the wound on 9/24/16. Interview with Physical Therapist (PT) #1 on 9/28/16 at 10:05 AM, in the PT department. confirmed the skin breakdown was caused by the knee immoblizer. Interview with the Physician on 9/28/16 at 12:d5 PM, in the conference room, confirmed the physician would expect the staff to regularly assess the resident for skin impairment under the knee immobilizer. Interview with the DON on 9/28/16 at 2:10 PMJ in the conference room, confirmed an assessment of the wounds on the right lower extremity was not completed to include the stage, size, and characteristics of the wound when identified on 8/27/16.

in summary, the facility falled to provide adequate

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/14/2016 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING, COMPLETED 445511 09/28/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6911 SNOW HILL ROAD LIFE CARE CENTER OF COLTEWAH COLTEWAH, TN 37363 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 314 Continued From page 8 F 314 skin assessments and interventions to prevent development of pressure ulcers from Resident #26's knee immobilizer on 8/27/16. Upon discovery of the pressure ulcers, the facility falled to conduct and document a thorough assessment of the pressure ulcers, including stage, size, and character. After development of the pressure uicers, the facility failed to follow orders for treatment every other day, resulting in a missed wound care treatment on 9/24/16 and the treatment not being done for 4 days. F 441 483.65 INFECTION CONTROL, PREVENT F 441 1) What corrective action(s) will be SPREAD, LINENS SS=D accomplished for those residents found to The facility must establish and maintain an have been affected by the deficient practice. Infection Control Program designed to provide a The four certified nursing assistants (CNA) safe, sanitary and comfortable environment and to help prevent the development and transmission on duty during the time of concern noted of disease and infection. on the 2567 received education on the facility's policy of Hand Hyglene, The DON (a) Infection Control Program and SDC completed this by 10/17/16. The facility must establish an Infection Control 10/28/16 Program under which it -(1) Investigates, controls, and prevents infections 2) How you will identify other residents in the facility: having the potential to be affected by (2) Decides what procedures, such as isolation, the same deficient practice and what should be applied to an individual resident; and (3) Maintains a record of incidents and corrective corrective action will be taken. actions related to infections. All residents have the potential to be affected by failing to follow facility's (b) Preventing Spread of Infection (1) When the Infection Control Program Hand Hygiene Policy. The DON, ADON. determines that a resident needs isolation to SDC, or Unit Managers, will randomly prevent the spread of infection, the facility must audit hand washing during meal service isolate the resident. for compliance 5 times a week for one (2) The facility must prohibit employees with a month, 3 times a week for one month, and communicable disease or infected skin lesions from direct contact with residents or their food if weekly for one month. 10/28/16

DEPARTMENT OF HEALTH AND HUMAN SERVICE PRINTED: 10/14/2016 CENTERS FOR MEDICARE & MEDICAID SERVICE FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938 0391 (X1) PROVIDER/SUPPLIER/CLI AND PLAN OF CORRECTION (XX) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER (X3) DATE SURVEY A. BUILDING_ 445511 B. WING NAME OF PROVIDER OR SUPPLIER 09/28/2016 STREET ADDRESS, CITY, STATE, ZIP CODE LIFE CARE CENTER OF COLTEWAH 5911 SNOW HILL ROAD OOLTEWAH, TN 37363 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (XS) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F441 Continued F 441 Continued From page 9 F 441 direct contact will transmit the disease. What measure will be put into place (3) The facility must require staff to wash their or what systematic changes you will hands after each direct resident contact for which make to ensure that the deficient hand washing is indicated by accepted professional practice. practice does not recur. Licensed Nurses and Certified Nursing (c) Linens Assistants have been in-serviced on the Personnel must handle, store, process and transport linens so as to prevent the spread of facility Hand Hygiene policy as of infection. 10/26/16 by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator or designee. This training will be completed in This REQUIREMENT is not met as evidenced orientation for all new associates Based on facility policy review, observation, and and quarterly thereafter. Any interview, the facility staff failed to wash or associates that have not been sanitize the hands during meal service in 1 of 4 in-serviced will not be allowed to work dining areas observed. until in-service completed. The findings included: The Director of Nursing, Assistant Review of the facility's policy Hand Hygiene, Director of Nursing, Staff Development revised 5/1/12, revealed "Purpose To decrease Coordinator, or Unit Managers will the risk of transmission of infection by appropriate randomly audit hand washing during meal hand hygiene...Handwashing/hand hygiene is service for compliance 5 times a week generally considered the most important single procedure for preventing nosocomial for one month, then 3 times a week for infections...If hands are not visibly soiled, use an one month, and weekly for one month. 10/28/16 alcohol-based hand rub for routinely decontaminating hands in all clinical situations..." Observation on 9/26/16 at 12:10 PM, of the 100 hall meal service, revealed Certified Nursing Assistant (CNA) #2 delivered a meal tray to a

resident's room, adjusted the tray table, touched a wheelchair in the resident's room, exited the resident's room, and without washing the hands or using hand sanitizer, removed a meal tray from

DEPAR CENTE	TMENT OF HEALTH	AND HUMAN SERVICES			Ą	RINTED	D: 10/14/2016 MAPPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	MB NO	2. 0938-0391 TE SURVEY MPLETED
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ļ,	PROVIDER OR SUPPLIER RECENTER OF COLT	EWAH			STREET ADDRESS, CITY, STATE, ZIP CODE 5911 SNOW HILL ROAD OOLTEWAH, TN 37363). <u>09</u>	/28/2015
(X4) ID PREFIX TAG	i (Each Deficiency	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DE	COMPLETION DATE
F 502 SS=D	another resident's recomputer from the tomashing the hands of removed another mathen used the ice so poured tea into the ganother staff members of the facility with the Diat 7:50 AM, in the contained hygiene was nother facility's policy with 483.75(j)(1) ADMINITED The facility must proservices to meet the facility is responsible of the services. This REQUIREMENT by: Based on facility policy with aboratory test as ordered to residents reviewed medications, of 26 residents reviewed medications, of 26 review of facility policy with the findings included Review of facility policy and included the findings included Review of facility policy and facility and	#2 then delivered the tray com, removed a laptop ray table, and without or using hand sanitizer, eal tray from the meal cart coop to place ice in a glass glass, and passed the tray er for delivery to a resident rector of Nursing on 9/28/conference room, confirmed of completed as required as not followed. STRATION The for the quality and timeling for the quality failed to obtain the facility	to 6 nd ess	F 441	4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur. The Director of Nursing or Assistan Director of Nursing will present resure of the audit and education bi-month three months to the facility Performance Improvement (PI) Committee. This committee consisting of the Execution Director, Director of Nursing, Medical Director, Director of Majorages.	olts ly for ance ve al on ion of ss	10/28/16

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 10/14/2016 FORM APPROVED

STATEMENT	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		(Y2) MUTUR	LE CONSTRUCTION		<u>: 0938-0391</u>
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:		A BUILDING		(X3) DAT	TE SURVEY
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NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	2010
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F 441	another resident's in computer from the washing the hands removed another mithen used the ice suppoured tea into the another staff members of 7:50 AM, in the computer interview with the part 7:50 AM, in the computer staff members of 7:50 AM, in the computer interview with the part 7:50 AM, in the computer interview with the part 7:50 AM, in the computer interview with the part 7:50 AM, in the computer interview with the part 7:50 AM, in the computer interview with the part 7:50 AM, in the part of the part	A#2 then delivered the tray com, removed a laptop tray table, and without or using hand sanitizer, leaf tray from the meal carcoop to place ice in a glass glass, and passed the tray er for delivery to a resider infector of Nursing on 9/28 onference room, confirment to completed as required was not followed.	t, 'to t	F 441			
- SS=D'	The facility must proservices to meet the facility is responsible of the services.	ovide or obtain laboratory e needs of its residents. The for the quality and timeling	ess	1 302	1) What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice. Resident # 165's PTT was obtaine 9/1/16, results were 30.3 within no	nt d on	e abiinidea e dening in the
	by: Based on facility por review, and intervier laboratory test as of 5 residents reviewe medications, of 26 residents.	1	in e		limits (Normal 22-34). On 9/2/16 MD notified and no new orders were received. 2) How will you identify other residenting the potential to be affected same deficient practice and what	ents :	10/28/16
	revised 08/2008, re- purpose of diagnosi procedures for obta services when orde physicianall orden	licy Diagnostic Services, vealed "it is the primary ic services to provide unifo ining necessary diagnostic		:	corrective action will be taken. All residents receiving Heparin have the potential to be affected. A 100% audit on all residents on Heparin the required monthly PTT was completed to 9/28/16 by the Unit Managers to ensure PTT was obtained as one	% nat ted	
ODM ONE OF	07/00 000 Paris				No other deficient practice was not	ed.	10/28/16

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				PRINTER	D: 10/14/2016 MAPPROVE
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BURLDIN	PLE CONSTRUCTION	OMB NO (X3) DA): 0938-0 39 TE SURVEY
NAME OF	PROVIDER OR SUPPLIER	445511		8. WING	STREET ADDRESS, CITY, STATE, ZIP CODE		MPLETED 1/28/2016
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(X4) ID PREFIX TAG	i (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	IDEC	(X5) COMPLETION DATE
F 514	physician's order" Medical record reviewas admitted to the diagnoses including Diabetes Mellitus 2, Pulmonary Disease Weakness, Anxiety Polyneuropathy. Medical record review 7/1/16 revealed "F time, a blood test the for blood to clot]m thinner]" Medical record review Administration Record review Administration Record for the parlin4th each more revealed the administration by staff with a composition of the PTT to be medical record review results for the PTT to be medical record for the medical record for the medical record for the medical record for the medical record for the medical record for the medical record for the Medical record for the medical record for the medical record for the Medical record for	ew revealed Resident #185 facility on 7/1/16 with Guillain-Barre Syndrome, Chronic Obstructive, Dysphagia, Muscle Disorder, Depression, and ew of a physician order data looks at how long it take onthly while on heparin [bit wo far the month of Augus TTmonthly while on nonth" Continued review stration record was initiale letion date of 8/4/16. Ew revealed their were no hat was documented as T results were available in or 7/26/16 and 9/1/16. Egional Director of Clinical at 2:15 PM, in the onfirmed the PTT was not	ed s ood	F 514	3) What measure will be put into p or what systematic changes you w make to ensure that the deficient practice does not recur. All licensed nurses will be in-service by the Director of Nursing, Assistant Director of Nursing, Staff Developm Coordinator and/or designee by 10/26/16 on the Diagnostics Service Policy to include promptly carrying physician orders for diagnostic service Daily Anticoagulant Review Flow (Exhibit D) has been revised to include date of the PTT and the results lab to ensure lab was obtained and on 10/17/16. Associates that have not been in-servill not be allowed to work until in-second to determine the completed. This education will be on in orientation for all new licensed numbered or Nursing, Staff Developm Coordinator, and/or Unit Managers audit the Anticoagulant Review Flow Sheet for results of the PTT we have included in the PTT we have included and in the PTT we have included and in the PTT we have included and in the PTT we have included and includ	ed at nent es out rices and w Sheet ude the reviewed erviced erviced erviced ompleted urses.	
	The facility must ma	intain clinical records on e	ach	-	1		

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/14/2016 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CINA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: X3) DATE SURVEY A BUILDING _ COMPLETED 445511 B. WING NAME OF PROVIDER OR SUPPLIER 09/28/2016 STREET ADDRESS, CITY, STATE, ZIP CODE 5911 SNOW HILL ROAD LIFE CARE CENTER OF COLTEWAH **OOLTEWAH, TN 37363** SUMMARY STATEMENT OF DEFICIENCIES (X4) (D 1h PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FUI (XS) COMPLETION DATE PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F502 Continued F 502 Continued From page 11 F 502 4) How the corrective action(s) will be physician's order..." monitored to ensure the deficient practice Medical record review revealed Resident #165 will not recur. was admitted to the facility on 7/1/16 with Director of Nursing, Assistant Director of diagnoses including Guillain-Barre Syndronie, Nursing will present the results of the audits Diabetes Mellitus 2, Chronic Obstructive Pulmonary Disease, Dysphagia, Muscle and education bi-monthly for three months Weakness, Anxiety Disorder, Depression, and as indicated to the facility Performance Polyneuropathy. Improvement (PI) Committee. This committee consisting of the Executive Medical record review of a physician order dated 7/1/16 revealed "...PTT [Partial thromboplastin Director, Director of Nursing, Medical time, a blood test that looks at how long it takes Director, Director of Maintenance, Director for blood to closs, monthly while on heparin blood of Rehab, Health Information Management thinner]..." Director, Director of Food and Nutrition Services, Director of Environmental Medical record review of a Laboratory Administration Record for the month of August Services, Director of Social Services, 2016, revealed "...PTT...monthly while on Business Office Manager, Director of heparin...4th each month..." Continued review Admission, and Director of Activities will revealed the administration record was initialled review the findings and make by staff with a completion date of 8/4/16. recommendations and develop plans of Medical record review revealed their were no action if any areas are noted to be results for the PTT that was documented as non-compliant. 10/28/16 obtained 8/4/16. PTT results were available in the medical record for 7/28/16 and 9/1/16. Interview with the Regional Director of Clinidal

483.75(I)(1) RES

F 514

SS=G

LE

Services on 9/28/16 at 2:15 PM, in the conference room, confirmed the PTT was not completed as ordered by the physician.

RECORDS-COMPLETE/ACCURATE/ACCESSIB

The facility must maintain clinical records on each resident in accordance with accepted professional

F 514

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/14/2016 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES DMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER; (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY A BUILDING __ COMPLETED 445511 8. WING 09/28/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5911 SNOW HILL ROAD LIFE CARE CENTER OF COLTEWAH OOLTEWAH, TN 37363 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID m PROVIDER'S PLAN OF CORRECTION PRÉFIX (ÉACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) Completion Date PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F514 F 514 Continued From page 12 F 514 1) What corrective action(s) will be standards and practices that are complete; accomplish for those residents found to be accurately documented; readily accessible; and systematically organized. affected by the deficient practice. On 9/27/16 the Director of Nursing The clinical record must contain sufficient information to identify the resident; a record of the provided education to RN #2 on resident's assessments; the plan of care and following Medication Administration services provided; the results of any Policy and Procedure preadmission screening conducted by the State; (documentation process). and progress notes. By 10/26/16 SDC or designee provided education to RN#2 on Wound Care This REQUIREMENT is not met as evidence# Procedure and Wound Care Treatment/ by: THE BEST OF Based on medical record review, observation Treatment Evaluation. 10/28/16 7---interview, and review of facility policy, the facility failed to ensure complete and accurate 2) How will you identify other residents documentation in the medical record for 1 (#26) having the potential to be affected by resident of 26 residents reviewed, resulting in the same deficient practice and what Harm to Resident #26. corrective action will be taken. The findings included: Pressure Ulcer Treatment Records of residents with pressure ulcers were Medical record review revealed Resident #26 was admitted to the facility on 8/18/16 with diagnoses reviewed, and a visual inspection of Including Fracture of Lower End of Right Femur, dressings was conducted by the Chronic Congestive Heart Failure, and Anemia. Director of Nursing, Assistant Director of Nursing and/or designee to ensure Medical record review of a Nurses Progress Note dated 8/27/16 revealed "...pt [patient] was being treatments are completed as ordered bathed and 2 new wounds were found on the 10/28/16

FORM CMS-2587(02-99) Previous Versions Obsciete

distal end of the calf. Wounds were approximately the size of a 50 cent piece. Wounds were covered by the knee immobilizer ... "

Medical record review of the Pressure Ulcer Status Record dated 8/29/16 revealed "...Date first observed 8/29/16 Location RLE [Right Lower

Extremity] (posterior-lateral aspect) stage

Event ID: dDFM11

Facility ID: TN3317

by 10/19/16.

If continuation sheet Page 13 of 17

DEPAR CENTE	TMENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES	3		F	RINTE	D: 10/14/20 MAPPROV	116 FC
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLL/ IDENTIFICATION NUMBER:		•	LE CONSTRUCTION	(X3) D	O: 0938-03 ATE SURVEY DMPLETED	<u> </u>
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NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> 0</u>	9/28/2016	
	RE CENTER OF COLT] 1	5911 SNOW HILL ROAD DOLTEWAH, TN 37363			
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	unstageable 8 [leng [centimeters] depth 100%drainage sm sanguinous" Medical record revie dated 9/20/16 revea previous tx orders R NSS [Normal Saline Iodosorb, cover [with QOD [every other date administration record revealed REE Pos pat dry. Apply iodoso [change] QOD [and] the treatment record record was initialed care had been comp Observation with Reg 9/26/16 at 11:00 AM, in a wheelchair in the observation revealed (RLE) extremity date. Observation of Residinterview with Licension 9/26/16 at 12:15 Pedescribed the wound areas, both 100% need forown drainage duthe wounds. The would centimeters) length x and 3.8 cm width x 3 Medical record review	th] x 3.5 [width] cm 0 Necrotic Tissue allcolor serous W of a Physician's Order led "D/C [Discontinue] a LE Posterior: cleanse [wit Solution], pat dry, apply all dry dsg [dressing] [char ay] [and] pm [as needed]. W of the treatment d for September 2016 sterior: Cleanse [with] NS arb, cover [with] dry dsg pm " Continued review s revealed the treatment on 9/24/16, indicating would leted. Gistered Nurse (RN) #1 or revealed the resident sea resident's room. Continue a dressing to the right love d 9/22/16. ent #26's wounds and ed Practical Nurse #1 (LP M, revealed LPN #1 on the posterior RLE as a crotic, with a small amount e to the product applied to nds measured 3 cm 1.2 cm width x 0 cm depth. To f a pursing note detect of a pursing note detect	h] ige] S. of nd ited ed ed ver	F 514	F514 Continued	on are ent rs y ant	10/28/16	
_ 18	728/16 at 7:50 PM re	vealed, "LE [late entry] for	-					

DEPARTMENT OF HEALTH AND HUMAN SERVICES GENTERS FOR MEDICARS & MEDICAID SERVICES

PRINTED: 10/14/2016 FORM APPROVED OME NO 1938-5301

STATEMEN	TOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLI/	_	1		MB NC	2 0938-039
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NAME OF	PROVIDER OR SUPPLIER	<u> </u>	 	1	STREET ADDRESS, CITY, STATE, ZIP CODE	09	/28/2016
LIFE CA	RECENTER OF COLT	PENALI			5911 SNOW HILL ROAD		
		EMMU			OOLTEWAH, TN 37363		
(X4) (D	SUMMARY STA	TEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTIO		· · · · · · · · · · · · · · · · · · ·
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	dated 9/20/16 revea previous tx orders R NSS [Normal Saline Iodosorb, cover [with QOD [every other date administration recommed administration recommed at the treatment record record was initialed care had been composervation with Reg 9/26/16 at 11:00 AM, in a wheelchair in the observation revealed (RLE) extremity date Observation of Resid Interview with Licenson 9/26/16 at 12:15 Fedescribed the wound areas, both 100% neof brown drainage dathe wounds. The would (centimeters) length and 3.8 cm width x 3 Medical record review	th) x 3.5 [width] cm 0Necrotic Tissue vallcolor serous allcolor [Discontinue] all color september cleanse [with color september cleanse [with] all color september 2016 all color september 2016 all color september 2016 all color september 2016 all color september 2016 all color serous all color	of ind mated wer N)	F 51	The Director of Nursing, Assistant DON, Staff Development Coordinator, and 2nd Shift Supervisor will randomly at two pressure ulcer treatment records residents with pressure ulcers to visu inspect dressing to ensure pressure treatments are conducted as ordered times a week for two weeks, 3 times for two weeks, and 1 time a week for months. 4) How will the corrective action(s) whose monitored to ensure the deficient practice will not recur. The Director of Nursing or Assistant Director of Nursing will present results of the audit and education bi-monthly to the facility Performance Improvement (PI) Committee. This committee consisting of the Executive Director, Director of Maintenance, Director, Director of Maintenance, Director, Director of Maintenance, Director of Food and Nutrition Services, Director of Environmental Services, Director of Social Services, Business Office Manager, Director of Admission and Director of Activities will review the findings and make recommendations and develop plans of action if any	didit of tally ulcer I for 5 , a week two	10/28/16
	ine wounds. The wol (centimeters) length :	inds measured 3 cm < 1.2 cm width x 0 cm der			Office Manager, Director of Admission	ns,	
	of brown dreinage du the wounds. The wou	ie to the product applied t inds measured 3 cm	۰		Director of Social Services, Business Office Manager, Director of Admission	ns,	
1	and 3.8 cm width x 3	cm length x 0 cm depth.		!	findings and make recommendations	ie	
	9/26/16 at 7:50 PM re	v or a nursing note dated evealed, "LE [late entry] f)T		areas are noted to be non-compliant.	ľ	10/28/16

DEPAR CENTE	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROMDER/SUPPLIED/CLIA						FORM	: 10/14/2016 APPROVED
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F 514	9/24/16; RLEclea done. First attempt willing to come into changed. Second a	ge 14 nse and dressing change i pt was not available and i her room to have dressing ittempt, this nurse talked p ige, but was called away to	iOt B	F5	14			
	9/27/16 at 7:45 AM, confirmed the treat	ment record was not accur	ate					
F 520 SS=G1	9/24/16) on 9/27/16	BERS/MEET		F 52				
	assurance committe nursing services; a p	ain a quality assessment a e consisting of the director hysician designated by the lighter members of the	of	i .				
	issues with respect to and assurance activit develops and implem	ent and assurance east quarterly to identify o which quality assessmenties are necessary; and tents appropriate plans of tified quality deficiencies.	t			·		
	A State or the Secre disclosure of the reco	tary may not require ords of such committee						

		AND HUMAN SERVI & MEDICAID SERVI		and a second of		FORM	10/14/2016 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(XI) PROVIDER/SUPPLIES IDENTIFICATION (YUM	vclia BER:	(X2) MULTIPI A. EUILDING	LE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
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LIFE CAI	RECENTER OF COL	TEWAH		.11	911 SNOW HILL ROAD DOLTEWAH, TN 37363		
(X4) ID PREFEX TAG	SUMMARY STA (SACH OBERDIENC REGULATORY, OR L	NTEMENT OF DEFICIENCIES (AUSTEBE PRECEDED DY ECHOENTIEVING INFORMA	OCT.	.ld PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEPICIENCY)	RE	COMPLETION CATE
F 514	9/24/16: RLE, cle done. First attemp willing to come into changed: Second	ige 14 anse end dressing ch t, pt was not available ther room to have dre attempt, this nume to nge, but was celled a	and not asings ked pt	F 514			
	9/27/16 at 7:45 AM confirmed the trea	Director of Nursing (D , in the DON's office, tment record was not hange had not been o 9/24/16.	accurate				
F 520 8S=G	who documented to 9/24/16) on 9/27/14 Station, confirmed completed on 9/24, 483.75(o)(1) QAA		n ursing	# 52 0	What corrective action(s) will accomplished for those resident found to have been affected by deficient practice.	ts	
	assurance committees; a	tain a quality assess se consisting of the d physician designated 3 other members of	irector of		On 10/13/16 the care plan and physicians order were clarified a revised for Resident #26 by an to utilize a right knee brace slee (immobilizer) when participating	RN ve	
	committee meets a issues with respect and assurance acti develops and imple action to correct los	ment and assurance t least quarterly to ide to which quality asse vides are necessary; ments appropriate pa antified quality deficie	sement and ans of icles.		therapy only, and for therapy to assess skin integrity after each treatment session. The therapis document findings in the daily nearly if any changes are noticed to	t will otes,	
<u></u>	A State or the Sec disclosure of the re	retary may not require cords of such commit	tee		will report to the Director of Rehab/Assistant Director of Reh	ab,	10/20/16

DEPART	TMENT OF HEALTH AND HUMAN SER	VICES			PRINTED:	10/14/2016
_CENTE	RS FOR MEDICARE & MEDICALD SER	NCES			Form	APPROVED
STATEMENT	OF DEFICIENCIES (X1) PROVIDERISUPPLI		I WALLER TO		<u>OMB NO.</u>	0938-0391
AND PLAN (CORRECTION IDENTIFICATION NO	HABER:		LE CONSTRUCTION	(X3) DAT	E SURVEY
1	į.) A BUILDING	} ************************************	COM	PLETED
fi .	445511]	B. WING		4	
NAME OF	PROVIDER OF SUPPLIER	 			09/	28/2016
[-	•			STREET ADDRESS, CITY, STATE, ZIP CODE	, ,	
LIFE CA	re center of qoltewah			5911 SNOW HILL ROAD		
		 		OOLTEWAH, TN 37363		
(X4) ID PREFIX	8UMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MUST BE PRECEDED BY	dera (PREFIX	PROVIDER'S PLAN OF CORRECT	ON	(X5) COMPLETION
TAG	REGULATORY OR USC IDENTIFYING INFORM	ATTON)	TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	PRIATE	DATE
		<u> </u>	<u>. </u>	DEFICIENCY		•
		1		F520 Continued	- (**) - (*)	
[, F-520]	Continued From page 15	ł	F 520	On 9/27/16 Director of Nursing	provided	; [
	except insofar as such disclosura is reli	ated to the		education to RN #2 on following	ı tha	ŧ .
! !	compliance of such committee with the					•
ł.	requirements of this section,	!	1 ,	Medication Administration Police	yand	
į	Good faith attempts by the committee t	A idoptifi.		Procedure (documentation proc		•
•	and correct quality deficiencies will not a basis for senctions.	t be used as videnced envalue.		By 10/26/16 SDC/designee will	provide	:
			[education to RN #2 on Wound (Care	:
			[Procedure and Wound Care/Tre		<u>{</u>
	<u>.</u>		{	Evaluation.	sarinent	
· 1	This REQUIREMENT is not met as evi		Ì	L valuation.	. 4	•
Ţ j	by: Based on medical record review, obse		ļ :	The Nurse who documented the	, 1	
	review of facility survey history, and inte			progress note on 8/27/16 will re		
ľ	facility Performance Improvement (PI)			education by the DON, ADON, o		
1.	falled to ensure substantial compliance	with	:			
.] .	federal regulations was maintained for a	towartion '		SDC/designee on completing a	Pressur	
1	Of pressure vicers and accurate medical	recorde		Ulcer Assessment and documen		. }
1 '	l resident (#28) of	26	, ,	assessment at the time of identi		` (
1.	residents reviewed.		:	and Pressure Ulcer/Non-Pressu	re 🕯	. [
1 .	The findings included:]		Treatment Plan (algorithm) by 1		
1 1	,			· ·	H ₂	ì
] !	Medical record review, observation, and	interview		The Director of Nursing, Assista	nt]	.]
1 1	Tevealed the facility tailed to provide add	Annata I		Director of Nursing, Staff Develo	pment	. 1
1	skin assessments and Interventions to I	revent		Coordinator, Unit Managers, MI	ıs İ	· ').
1 1	development of pressure ulcers from Re	sident	,	Coordinators, and 2nd shift Sup]
1 !	#26's knee immobilizer on 8/27/18. Upodiscovery of the pressure closes, the fact	an Tananan	: 3	will be educated on the ABCs of		. [
1	to conduct and document a thorough as	anth taned		Wound Care (online credentials		
	of the pressure ulcers, including stage,	size and		(<u> </u>	1
f .]	Character. Atter development of the pre	Reune i	:	continuing education) by 10/26/	16. j	[
1	uices, the facility falled to follow orders s	kr i		The Executive Director (ED) will	, 1	<i>'</i> [
1 . 1	treatment every other day resulting in a	missed			1	į.
†	wound care treatment on 9/24/16, and to treatment not being done for 4 days.	pe [1	educate the Performance	1:	ŀ
<u> </u>	annulation real field field total district		1	Improvement (PI) Committee or		f
1.	Medical record review, observation, and	interview		facility Performance Improveme		. 1
1	revealed the facility failed to ensure com	olete and t	4	Program Policy, and the require	ment 🗜	ľ
	accurate documentation in the medical	ecord for	'	for this Committee to ensure	1.	10/28/16

for this Committee to ensure

DEPAR'	TMENT OF HEALTH	AND HUMAN SERV	CES			PRINTE	D: 10/14/20 MAPPROVE
*PINTEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIES IDENTIFICATION NUM	BICLUA .	(X2) MULTU A. BUILDING	PLE CONSTRUCTION	OMB M	D. 0938-03 TE SURVEY
<u></u>		445611	İ	B. WING_			
NAME OF	PROVIDER OR SUPPLIER			<u> </u>	STREET ADDRESS AND ASSESSED.	09	/28/2016
LIFE CA	RE CENTER OF OOL	rewau	ļ		STREET ADDRESS, CITY, STATE, ZIP CODE 5911 SNOW HILL ROAD	•	
2			.		COLTEWAH, TN 37363	•	
(X4) ID PREFIX TAG	I DAGH DEFICIENCY	TEMENT OF DEPICIENCIES MUST BE PRECEDED BY S SC IDENTIFYING INFORMAT	4	PREFIX TAG	PROVIDERS FORM OF BORRES CACH CORRECTIVE ACTION SHOW CROSS REFERENCED TO THE APPR DEFICIENCY	ITON JLD BE OPRIATE	COMPLETION DATE
E 520	Do do III			F	F520 Continued		
F 020	Continued From page	gė 16		F 520	substantial compliance with fed	terel	}
	breazhte nicet fleat	ments for Resident#	26.		regulations to include prevention	on and	
)	Review of the facility	y's annual Recontilica	lino i		treatment of pressure ulcers ar		1
1	5U[VOVS revealed the	e facility was alted fall	1 - 1	:	accurate medical records. The		1
	deficient practices a	t 483.25, prevention re ulcars, and 483.75	and .	!	Includes the Committees response		1
1	accurate medical re	cords, at a scripe and	lanau izultus	į:	to monitor, evaluate, and ensur		
<u> </u>	OF U DE DE SENNUAL	Survey dates of 6/18	2014	,	appropriate follow up action. The		1.
}· ·	and 9/17/2015,				occur by 10/26/16. This commi		1
1	Interview with the Ex	reculive Director (ED	المحالة المناسون		consists of the Executive Direc		1
1	THE CHOICH BY THUS THE	LICINI ON SIDEMA SI 1	iann bia 1		Director of Nursing, Medical Di		:
	ALCOHOLOGICA LO	GIII: ISBITITION OF THE AN	William !		Director of Maintenance, Direct		
	Dioblems and with M	icere and cocuments ans into place when i	tion	-	Rehab, Health Information Dire		
1	ayere Josephinicaett. Comi	المراجع والمنافقة المنافقة	Annalis 1		Director of Food and Nutrition 5		<u>k</u>
į.	THE DITTOURS IN GLACK	Mar for the link was	exers to		Director of Environmental Servi		
7.	JOHNSON CHARACTER OF HER TH	HICCOMPROMINATION I		•			J. *
	Teetrients are come	da) sind make sure t letedwe will do son	D soci		Director of Social Services, But		
13	saccingdentiled	EST WERK Some	io apot .	ş	Office Manager, Director of Adi and Director of Activities	TISSIONS	
	documentation issue	\$"	1, 1	3	[*-		10/28/16
-	Further interview with	the ED and DON on	[]		How will you identify other re	sidents	!
17	NEGOTO ATRICHMENT	Market State and	b 1	1	having the potential to be affect	ed by	ļ <u>.</u> .
£:A	ANTONINES THEY INUIS	351 heed to public a	reference h		same deficient practice and who	- 41	•
3	Continued Interview of	i Wilness statements confinited "changes		1	corrective action will be taken.	j	
1:1		Description of Alack 1997	4	· .r	An audit was conducted to ident	j 	-•
	components aschille	W Himbaldianna in	discuss		residents with orthotic devices to		
į v	in permitting 12 Till	re is a recurring pro- omething else to wo	NESera I		ensure care plan interventions in		· \$
ď.		· · ·	38/44		assessment of orthotic device a		į
i f	Refer to F-314 and F-	-514	F		skin integrity by DON, DOR, RN		. :
					designee by 10/13/16. All care p		
	•	·	l li		were reviewed and revised as a		
[-		.	[- [
		·			esult of the audit by the DON are 10/13/16.		10/28/16
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CENTERS F-OR MEDICARS & MEDICALD SETA CCS STREAMENT OF DEFOCICES AND PLAN OF CORRECTION 445511 ANALY OF PROVIDER OR SUPPLIER 445511 ANALY OF PROVIDER OR SUPPLIER 445511 ANALY OF PROVIDER OR SUPPLIER 445511 ANALY OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF COLTEWAH FRANCE CENTER	DEP CEN	ARTMENT OF HEALTH	AND HUMAN SERV	CES		,	PRINTED: 10/1	14/201
### August of Provider on Supplier UFE GARE CENTER OF DOLTEWAH STREET FADDRESS, CITALSTATE, 2P CODE	STATE	MENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIE	R/CHIA	(X2) MULTU A. BUILDIN	PLE CONSTRUCTION	OMB NO. 093	8-039 VEY
UFE CARE CENTER OF COLTEWAH COULTEMAN, This 37939 Continued From page 16 pressure ulcer treatments for Resident #06. Review of the facility's annual Recertification surveys revealed the facility was cited for deficient practice at 483 25, prevention and treatment of pressure ulcers, and 493,74 accurate membrane under the process are surveys revealed the facility was cited for deficient practices at 483 25, prevention and treatment of pressure ulcers, and 493,74 accurate membrane treatment of pressure ulcers, and 493,75 accurate membrane treatment of pressure ulcers and 493,75 accurate membrane treatment of pressure ulcers, and 493,75 accurate membrane treatment of pressure ulcers and fapplicable provide treatment of pressure ulcer and if applicable provide treatment of pressure ulcer and accurate assessment of pressure ulcer by 10/13/16, No new pressure ulcer by 10/13/16, No new pressure ulcers were identified. The Pressure ulcer Treatment Records for residents with pressure ulcers were identified. The Pressure Ulcer Treatment Records for residents with pressure ulcers were treatments are completed as ordered by 10/19/16. Further interview with the ED and DON or 4/28/16 is 250 BM; in this conference morning problem. Confidence interview with the ED and DON or 4/28/16 is 250 BM; in this conference morning in the property of the pressure ulcers including stage, size, and character was conducted and documented by 10/19/16. Pressure Ulcer Status Records were reviewed by the DON, ADON, and/or designee to ensure a through assessment of the pressure ulcers, including stage, size, and character was conducted and documented by 10/19/16. Refer to F-314 and F-514 The Pressure Will be put into place or what systematic changes will you make to ensure that the deficient does not recur.		<u></u>	445511	<u> </u>	B. WING		1	
F 520 Continued From page 16 pressure ulcer treatments for Resident #6. Review of the facility's annual Recertification surveys revealed the facility was cited for definient practices at 483.25, prevention and treatment of pressure ulcers, and 483.75 accurate medical seconds, at a scope and several problems and put plane into place when pages were identified. Continued interview confirmed the process in placeness for the Unit Managers and if applicable provide treatment of pressure ulcers and 483.75 and 197.2015. This view with the Essective Director (ED) and the Director of Mixing (ED) and the complete an accurate assessment of pressure ulcer and complete an accurate assessment of pressure ulcers were identified. Continued interview confirmed the general facilities and put plane into place when bases when the recordence, identified fact week come documentation issues Further interview with the ED and DON or 1922/16 at 390 BM, in the conference according and several time, expected time, exp	J.					5911 SNOW HILL ROAD	09/28/20	<u> </u>
F 520 Continued From page 16 pressure ulcer treatments for Resident #26. Review of the facility's annual Recertification surveys revealed the facility was cited for deficient practices at 432.55 prevention and treatment of pressure ulcers, and 493.74 accurate mentional reports at a scape and sequently of "D" on the arinual survey dates of unit 2014. The pressure ulcer and if applicable provide the unit of pressure ulcers and comment of pressure ulcer and integrity to prevent development of pressure ulcer and if applicable provide the arinual survey dates of unit 2014. The pressure ulcer and if applicable provide the amount of pressure ulcer and complete an accurate assessment of pressure ulcers were integrated at pressure ulcers and complete an accurate assessment of pressure ulcers were integrated at pressure ulcers were integrated at pressure ulcers and integrity to pressure ulcers and complete an accurate assessment of pressure ulcers were reviewed, and visual inspection of dressing was conducted by the DON, and/or designee to ensure treatments are completed as ordered by 10/19/16. Further interview with the ED and DON or provided they (notice) and the pressure ulcers were reviewed by the DON, ADON, and/or designee to ensure the pressure ulcers, including stage, size, and character was conducted and documented by 10/19/16. Refer to F-314 and F-514 3) What measures will be put into place or what systematic changes will you make to ensure that the deficient does not recur.	PRE	ID SUMMARY STO FIX (EACH DEPICIENCE S REGULATORY OR L	ATEMENT OF DEFICIENCIES Y MUST BE PARCEBED BY SC IDENTIFYING UNFORMA	GLL IDN)	ID PREFX	PROVIDENT HAN OF COURSELY TEACH CORRECTIVE ACTION GROUD CHOSE REFERENCED TO THE OPPIN DEPICIENCY	ON- LABE COMP PRIATE 0	IXS) PLETION MATE
FORM CMS-2507 (02-49) Provious Versione Obsolete Even (0: ODPM1) FACILITY TAXABLE		Review of the facilities urveys revealed it deficient practices treatment of pressurations are used in the arms and 9/17/2015. Interview with the Edicator of D' on the arms and 9/17/2015. Interview with the Edicator of DW ship in the conference of focked at pressure problems and put place ware identified. Contine process in place " flip through the Todard in the process in place " flip through the Todard in the process in place treatments are companied to the process in place treatments are companied to the process in place treatments are companied to the process in place treatments are companied to the process in place treatment interview with a sommittee the put in companies and the put in companies each thin committee. Yes the and we need to find. Refer to F-314 and F	tments for Resident # y's annual Recertifica te facility was cited for at 483.25, prevention the ticers, and 483.75 toords, at a scope and il survey dates of 6/15 xecutive Director (ED (DDN) on 9/28/16 at ton, Continued the op- licers and document ans into place when i finued interview confi- trices for the Unit Mar ARS (Treatment tride) and triake sures toletedwe will do son last week some son the ED and DON or in the conference roo as a med to put in in with ess statements for the statements for the statements for the conference roo as a med to put in in with ess statements for the statement for the stateme	severty 2014 Send the 2014 Sen		Unit Managers, ADON and MD conducted a 100% skin audit the included residents with orthotic devices to ensure assessment integrity to prevent developmer pressure ulcer and if applicable treatment of pressure ulcer and complete an accurate assessment pressure ulcer by 10/13/16. No pressure ulcers were identified. The Pressure Ulcer Treatment of residents with pressure ulcers reviewed, and visual inspection dressings was conducted by the ADON, and/or designee to ensure atments are completed as on by 10/19/16. Pressure Ulcer Status Records reviewed by the DON, ADON, a designee to ensure a thorough assessment of the pressure ulcer including stage, size, and characted was conducted and documented 10/19/16. 3) What measures will be put in place or what systematic change will you make to ensure that the	S Nurses nat of skin nt of provide ent of new Records s were of DON. ire dered were nd/or ers, oter I by 10/28	/16

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CENTE	RS FOR MEDICARE	AND HUWAN SERV	NCES			PRINTE	D: 10/14/201
1 2 IATEMEN	T OF DEFICIENCIES	I(X1) PROVIDER/SUPPLIE	BIPI 14	5 mm 4 mm m	Marie de la companya	OMB NO	M APPROVE 3: 0938-039
ANDPLAN	IDENTIFICATION HUN		BER:	A. BUILDIN	IPLE CONSTRUCTION	(X3) DA	ATE SURVEY
NAME OF	PROVIDER OR GUPPLIER	445511		B. WING_			Sea_125
1				-	STREET ADDRESS, CITY, STATE, ZP CO	OE US	12812016
-	RE CENTER OF COL				5911 9NOW HILL ROAD OOLTEWAH, TN 37363	•	
(X4) IO PREAX	SUMMARK STA	TEMENT OF DEPICIONCIES FIREST DE PRECEDENTRY	0.00	10	PROVIDER'S PLANTE CODE	ECTION	
TAG	REGULATORY OF C	SCIDENTIFYING NEORINA	DEC.	PREFIX TAG	CROSS REPERSUCED TO THE ALL	PROPRIÁTE PROPRIÁTE	COMPLETION DATE
F 520	Continued From pa	na 16			F520 Continued	· · · · · · · · · · · · · · · · · · ·	
	pressure vicer treat	ments for Resident#	26	F 52	lopal licensed nurses will be in		1
	ľ			ļ.	on the care plan revision pro		1
	Review of the facilit	y's annual Recertifica	tion		include assessment of ortho		1
]	i pericient practices a	e facility was olded for If 488,25, prevention	bad	1	and skin integrity by the DO		}
<u> </u>	i weather of bressi	ie uidero santago 75	1	1	and SDC or designee by 10	/26/16.]
) 14001173(UB 1710-011073) ftb	COTOS: At a servera and	t more course.	y	All MDS Coordinators will be	e in-service	d
	and 9/17/2015	Survey dates of 6/16	2014		рл the care plan revision pro		
ļ j	Aces and a second	to blocket and a			include assessment of ortho		•
	Interview with the Executive Director Director of Mulsing (DOM) on prize/	xeoulive Director (ED	ED) and the	2:}	and skin integrity by DON, o	r RN	ŀ
. 1	ALTHOUGH THE BOOK TO	OTT. CONTROLLER THAT A	and the	1	designee by 10/26/16.		ļ
	TOOKED BY DISSELIE	licers and document	diren.	; [All licensed nurses and then	aniete	ĺ
ť 1	PRODUBING BUILDING BUILDING	ans into place when i linued interview confi	00110 CV	1	will be educated on the Orth] .
		MORE PROPERTY AND NAME.	men].	Documentation and Commu		e manganan a
E. I	一种动物的 医水色性阿拉氏氏征				Process by the DOR, ADOR		#THY.
	Administration Reco treatments are comp	(CS) and make sure t	1¢	į.	ADON, or SDC/designee by	10/26/16.	f .
11:5		last wook come	re spot	1	1		
]	documentation issue)5"	٠,		The DON, ADON, and Unit I will use an audit tool to audit	nanagers .	
 	Further interview will	the ED and DOM ~			physician orders and ensure		:
43	SECULO BEX IXI PAR	M Han marking and a single	4-34	}	plan interventions include as		
17	Amin'i Niggi TiGA (UGLA	BOK TRACTOR THE TOP	SI/Ocino		of orthotic device and skin in		
[2]	notes what they puri Continued interview (COMMINION AND THE PROPERTY OF THE PARTY OF T	. 1		the Clinical AM Meeting which		
1.	ugauneni nursesek	the he moderate	****	! ;	of DON, ADON, DOR or ADO		. "
94	GUH I DUHUNUS HACK AR	THE SPORTS HAVE BOOM AND	- Paris and the second		Coordinator and Unit Manag		
13 13	in comunities. Yes the end we need to find a	omething ales in	Nêm '	1	per week for one month, 3 tir	ar, o umesi	- 1
1.			Print.		week for one month, and the		
. [1	Refer to F-314 and F	- 514			per week for one month.	t	1000:
ļ.		·]	r woon is one mondi.		10/28/16
}			ĺ				.]
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Facility ID: TN2317

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CENTERS FOR MEDICARE	& MEDICATO SERVICES			PRINTED: 10/14/201 FORM APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIENCLIA IDENTIFICATION NUMBER:	(X2) MULTE A BUILDING	TE CONSTRUCTION	OMB NO 8838-639 (X3) DATE SURVEY COMPLETED
****	445611	B. WING		
NAME OF PROMOER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	09/28/2016
LIFE CARE CENTER OF OOLT			5911 SNOW HILL ROAD COLTEWAH, TN 37363	
(XA) ID SUMMER STR PREFIX TEACH DENICE NOV TAG REGULATORY OR 1.	PLENT DE DESCRIBIES MUST DE PRECEDES ET PAL E (GENTE UNG DE SPILA TON)	PREFIX TAG	PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD CROSS REPERENCED TO THE APPRODE DEFICIENCY)	ON (KS) DO BE CONTRETION BRIGHTE DATE
. 1	ments for Resident #25.	F-580	F520 Continued The DON, ADON, SDC, Unit M MDS Coordinators, and 2nd Sh	anagers lift
surveys revealed the delicient practices a treatment of pressur accurate medical report of "D" on the annual and 9/17/2015. Interview with the Estimated in the conference for the conference for problems and put places identified. Continuity the property in the propess in place of the propess in place of the propess in place of the propess in place of the propess in place of the propess in place of the propess in place of the propess in place of the propess in place of the propess in place of the propess in place of the propess in place of the propess in place of the propess in place of the propess in place of the propess in place of the propess in place of the propess in place of the	ds) and make sure life. letedwe will do some apot ast week some		Supervisor will be educated on ABCs of Wound Care (credenticontinuing education) by 10/26/All licensed nurses will be educated on Medication Administration Pland Procedure and Wound Care/Tracedure	aled (16. ated colicy e eatment orders ders intee
documentation issue fruither interview with 9/20/16 at 200 PM, is confirmed they (nurse notes what they put is Gontinued interview of freetment nursesed comparises each the	ine ED and DON of the conference real, and polying the conference real, and pursing twiness statements. The conference and the conference are probably need to discuss the serecuring problem omething also to work.		Assessment and documenting assessment at the time of Identic and Pressure Ulcer/Non-Pressure Ulcer Treatment plan (algorithm) 10/26/16. The Director of Nursing, Assista Director of Nursing, Staff Develor Coordinator, Unit Managers, MC Coordinators and Second Shift Supervisor will audit Medication Administration Records for all rewith orthotic devices to ensure	fication re) by nt epment SS
RM CMS-2567(02-98) Provious Versions Ob	10%to Evan 10; QDF/41		assessment of skin integrity to p development of pressure ulcer in	

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If continuation sheet Page 17 of 17

	CENT	ERS FOR MEDICARE	ANU HUMAN SERV	VICES			PRINTED: 10/14/2	2 016
	STATEME	TOF DEFICIENCIES			<u> </u>	*************************************	FORM APPRO	VEC
	AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	R/CLIA ABER:	A BUILDIN	FLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	7	·	445511		B. WING	<u> </u>		
	NAMEO	PROVIDER OR SUPPLIER		, ,		STREET ADDRESS SITY, STATE OF CODE	09/78/2016	<u>i</u>
i	Life C	ARE CENTER OF OOL	rewah			5911 SNOW HILL ROAD	•	
		···		·	1	OOLTEWAH, TN 37363		
•	PREFIX TAG	(EACH DERICENCY REGULATORY OR L	TEMENT OF DEFICIENCIE **CLST DE PRECEDED BY SC IDENTIFYING INFORMA	FULL FION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERICY)	DN (X5) D 8E COMPLETE PRIATE DATE	IÓN
1	F 520	, , , , , , , , , , , , , , , , , , ,		-	1	F520 Continued		
	1. 200	12			F 520	Clinical AM Meeting 5 times a v	week for	4
		pressura ulcer treat	ments for Resident #	26.		one month, 3 times a week for	one :	i
1		Ravious of the facility	de exercel Properties]			
1		SUIVAVE tavesied th	y's annual Recertific e facility was cited to	tion		month, and 1 time a week for o	ue i	1
j		'i dencient practices e	t 483.25. prevention	and		month.	i i	
		I PRAIMENT OF DIRECT	e ulcers and des 74	:	j	The DON, ADON, SDC, Unit Ma	anagers	
Ţ	Ì	ECCUPATE (TRACES) TO	cords all recono do	i couronn]	MDS Coordinators and 2nd Shif		- 1
1		of 'D' on the annual and 9/17/2015.	survey dates of 671	2014		Supervisor will randomly audit to		ļ
ļ	.	Sitting at 12 (legistral).				Pressure Ulcer Treatment Reco		-1
1	,	Interview with the E	Recuitve Director (Fr	h sand tha				
1		A DURGON OF NUMBER	ንገርባለነነ ሦስ ከለመውጠል አል	A MEN CORRE		residents with pressure ulcers to		4
1	•	a strains connectence to	Office Confirmed the A	ministes	,	visually inspect dressing to ensu		
1		I WANTED TO DESCRIPTION OF		A Clarket	,	pressure ulcer treatments are co		Į
1		problems and put pl were identified. Con	iinued interation eest	ا حسسده		as ordered 5 times a week for ty		- 1
1		1 444 IN TOPS 10 DIECE	Was for the Link Hol	lacers to		3 times a week for two weeks, 1	time	1
ı	. :		UCS Phrophysian — I		i ,	a week for one month, and one	time_	1
1	•	Administration Rees	(US) alid make sure	te i	7	for one month.	•	- [
1		treatments are contractionsldentified	last week some	ne spot		The BON 4804 6	1	1
l		documentation issue	S"			The DON, ADON, SDC, Unit Ma	nagers	
ļ		Section and a contract of the		'	1	MDS Coordinators and 2nd Shift	. *	ŀ
1		Further Interview will	The ED and DON o) 1		Supervisor will audit pressure uto		Ţ.
ŧ		9/26/16 at 3:00 PM confirmed they (murs	HAR CONTENENCE FOR	m,		status records in the Clinical AM	ļ.	ľ
1		THE TEST WAS THE ALDER H	D WATERSK Stations a AM		Į	Meeting to ensure a thorough	. :]	ŀ
Į.		Committee interviews	Sprifficied " channel	1	f	assessment of pressure ulcer inc	:luding!	
ľ		SUBBLIDENT DURGES. OF	Himmilians of about 1999	L 19		stage, size and character was co		Ţ
ľ	ļ	components each fin	19: "bloospily ueed to	discuss		and documented 5 times a week		. ا
1		in committee, yes the and we need to like s	HE ICO INSTITUTO	Micros I		one month, 3 times a week for or		
		•		Thing?		then 1 time a week for one month	10/28/16	,]
ł	ŀ	Refer to F-314 and F-	-514	•	[The state of the post of the motific	1. 10/20/10	<u>'</u> -
ľ	1			}	ſ		-	1
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1					*		1	
<u>'</u>		<u> </u>			Į.]	1

SENTE	RS FOR MEDICARE	AND HUMAN SER	MCES		,	PRINTED	: 10/14/2010
SENTERS FOR MEDICARE & MEDICALO SER STATEMENT OF DEPICIENCIES AND PLAN OF CORRECTION DEPTERS FOR MEDICARE & MEDICALO SER (X1) PROVIDERISUPPLI DEPTERS FOR MEDICARE & MEDICALO SER (X1) PROVIDERISUPPLI DEPTERS FOR MEDICARE & MEDICALO SER (X1) PROVIDERISUPPLI AND PLAN OF CORRECTION			D/CIM PONEL			nne no	APPROVED
	PAN OF CORRECTION DENTIFICATION NE		MBER:	A. BUILDIN	e		E SURVEY MPLETED
MANEGE	,	445511		B. WING_			Limite
	PROVIDER OR SUPPLIER	_	-		STREET ADDRESS, CITY, STATE, ZIP CODE	09/	28/2016
LIFE CA	RECENTER OF OOL	rewah .		ľ	5911 SNOW HILL ROAD	. ,	
			_		OOLTEWAH, TN 37363		
(X4) ID PREFIX TAG	I CEACH DEFICIENCY	TEMENT OF DESIGIENCI MUST BE PRECEDED BY SC IDENTIFYING INFORM	i mara	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (CACH CORRECTIVE ACTION SHOULD CROSS REFERENCED TO THE APPRICACE DEFICIENCY)	on Dec Priate	COMPLETION OATE
F 520	Continued Come no	-14.40°		Ţ	F520 Continued		-
1 020	Continued From pa	ge 16		F 520	All licensed nurses will be educ	ated on i	•
•	pressure ulcer treat	ments for Resident:	#26 ,	'	following Medication Administra	tion	4.
;	Review of the facility	v's an nual Rece _{rtific}	elion	4	Policy and Procedure and Would		
	i Surveys revealed th	A facility were eited A		1	Procedure and Wound Care/Tre		•
	dendent practices a	ll 483,25, prevention	and	 			
-	rueaurient of bressu	re uicers and dad 7	r.	1	Evaluation to ensure treatment		
	of "D" on the annual	evins, era scobe al Estina	e seventy		are completed per physician ord	ter by	•
	and 9/17/2015	Same Acomo district	सर्वस्थाः । स्टब्स्	1	the Director of Nursing, Assistan		
ł	AND AND AND AND AND AND AND AND AND AND			<u></u>	Director of Nursing, Staff Develo		
ļ	Interview with the E Director of Russing (ecutive Director (2)	and the	•	Coordinator, and/or designee by	/	
	in the conference to	om cookman has	3.00 PM	٠	10/26/16.		!
" [WORKER ME THE COSTINE (LIGETS SIDE VIDENTAL	KKAN		Any associates who have not be	∍en Į	,
ļ	DIGENERAL THE THE	APP States will make a character	Yana aka 5		in-serviced will not be allowed to	> work 🚶	
	were identified, Con	inued interview con	imed		until in-service completed.	ſ	Ŷ
	the process in place " file through the Ye		"" " " " <u>" " " " " " " " " " " " " " "</u>		Training will be completed in original	entation	
36	WOLLDWICKS THE STREET	(distriction of the	tie .		for all new licensed associates.	Ī	- 4
313	WASHINGTON FILE COULT	NEIDE - NUN AND AND AND	me spot		The Director of Nursing, Assistan	nt -	- 1
	checking, identified documentation issue	2197/MPMANATATION			DON, Staff Development Coordi	nator,	,
1		3 "	,	1	Unit Manager, MDS Coordinator	and .]
	Further Interview with	WE ED and took a	ni i	1	2nd Shift Supervisor will random	lv auditi	
78.7	acouto eraing bid i	A til A ich Homonica de		:	two pressure ulcer treatment rec	ords	
	AALUHAN 467 - MAA "UJALS"	HELD	William I	j	of residents with pressure ulcers	-111	- 1
70	notes what they put Continued interview (MODEL Chares	ا ــــــــــــــــــــــــــــــــــــ		to visually inspect dressing to en		ľ
1.3	an soemin trentities.	HOWATHING OF ANALY - 1921			pressure ulcer treatments are co		•••
. 3	components each fin	6. probably need to	Ziščuss		as ordered for 5 times a week for		1
	Zimpedents osen tin n Coaunittee, ves tij ant ver soot 12 ties	re's a recurring pr	plem	- 4,	weeks, 3 times a week for two we	iwo j	
T.	and we need to find s	oneming exe to wo	iku. 1		and 1 time a week for two months		[,
	Refer to F-314 and F-	- 51 4					. f
. }		= -		:[.	he facility will be increasing the f	requency	′ ∫.
1.				<u>.</u>	of the Performance Improvement	(PI)	1
Ī		,			Committee meeting from monthly	to 1	
					i-monthly to ensure substantial		- 1
		a,		- h	OMNİDADA with fodosal		

STATEMENT	RS FOR MEDICARE	(KI) PROVIDER/SUPPLIE	IIUES.		· · · · · · · · · · · · · · · · · · ·	OMB No	APPROVE	١.
AND PLAN OF CORRECTION		DENTIFICATION NU	MBÉR:	A BUTLOIN	PLE CONSTRUCTION G	OMB NO: 09384 (X3) DATE SURVE COMPLETED		- T
		445811		8, WING		1		
NAME OF	PROVIDER OR SUPPLIER		-	** '	STREET ADDRESS, CITY, STATE, ZIP CODE	1 09	128/2016	
LIFE CA	re center of ool	TEWAH .	1		5911 SNOW HILL ROAD			_
					OOLTEWAH, TN 37363			
(X4) ID PREFIX TAG	I FACH DEFICIENCY	NEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	forus	PREFIX TAG	PROVIDERS PLAN OF CORRECT (EACH EXPRECTIVE ACTION SHOUL CROSS REFERENCED TO THE APPRO DEFICIENCY)	JON SE TON	COMPLETION DATE	4
F 520	Destinate Table 4	44		1	F520 Continued	·	 	٠.,
المحر ا	Continued From pa	ge 16 Iments for Resident (F 52	The Performance Improvemen	it (PI)	İ	
`.	!			l · .	Committee will review the findi	ings	<u>.</u>	ļ
	Review of the facilit	ys annual Recentific	ation	}	presented of the audits and ed	lucation		
ļ	surveys revealed th	ŀ		provided for all survey findings	;			
	gezonent of pressu	it 483.25, prevention raulcers, and 483.7	ž.	•	bi-monthly for 3 months to ens	ure		
	accurate medical re	unally intedical records, at a second on	d ciawarika		substantial compliance is met.	i		
1.1	or 12 on the enoug and 9/17/2015.	Survey dates of 6/1	92014	}	4) How the corrective action (s) will		
- 4	7 55			<u> </u>	be monitored to ensure the de-	ficient	r	1
11	Interview with the E	xecutive Director (EI	and the	ļ.	practice will not recur.			1
	CHECKE OF INDIBINA	ILKUNTING 9/9/8/16 or	Delta 1014	•	The Director of Nursing or Assi	stant		1
7	100kgp st blassnie i	ntereboe room, confirmed the c			Director of Nursing will present	. [1
ı l	PRODUCTES BAC BUT D	olans into place when Others interview and	047000	1		4.		1
· makes	were identised. Con the process in place		ANY ANY ANY ANY ANY ANY ANY ANY ANY ANY		of the audit and education bi-m	- 1		
. r	MIND UNDER THE 14	k)(%) T/MEIPONNA			for three months to the facility's			Ì
1	Administration Reco	i mine Allem Isme i Smil	ne en		Performance Improvement		,	ļ
	treatments are confi chacking_identified	Heredwe will do so	me spot	•	(Pi) Committee. This committee	e .		ļ
. [documentation issue	S"	0		consisting of the Executive Dire	ector.		l
į.	Further Interview will	filha en santan.		-	Director of Nursing, Medical Dir	. 4		ľ
configue folgewh Configue	80.2001 NO 781 POLICE I	Marian Company of the	/		Director of Maintenance, Direct	٠,	į	ŀ
	conflicting anevaluation	MANAGE AND STATES	ا بينيانك		Rehab, Health Information Dire	F		ŀ
		put in wilness statement lew confirmed "change			, <u>-</u>		,	١.
14					Director of Food and Nutrition S	- 1		ĺ
- 15	arringivents each im	16 THE NORTH PROPERTY	A	•	Director of Environmental Servi	ces.		
1.1	n committee. Yes th Indiwe heed to find t	MIN IS CONTOUND AND A PARTY	ATX		Director of Social Services,			
- 1			Taken.	.	Business Office Manager, Direc			
	Refer to F-314 and F	-514			Admissions, and Director of Act		i	
1		•		·	will review the findings and mak			
					recommendations and develop		1	
Į!		,		-	of action if any areas are noted	to be	[
. "					maa			

Event (D: QOFM1)

Feeting ID: YM3317

If continuation shoot Page 17 of 17

FORM CMS-2567(02-98) Previous Varsione Coscinto